Department of Mental Health, Mental Retardation and Substance Abuse Services

PLAN OF CARE SUMMARY

Check type of Waiver: ☐ **MR WAIVER** ☐ **DAY SUPPORT WAIVER**

Individual's Name: _____ (FIRST) _____ (LAST) _____ (M.I.) CSP Start Date: _____

Medicaid Number: _____ Date of last medical exam: _____ CSP End Date: _____

CSB: _____ Case Manager: _____ Phone: _____

Primary goals of the individual:

_____

_____

_____

_____

Living Arrangements (while in the MR Waiver)
Check any that apply:

- ☐ Lives with parents/relatives
- ☐ Lives alone in own home/apartment
- ☐ DSS-Approved Child Foster Care Home
- ☐ DSS-Approved Adult Foster Care Home
- ☐ Sponsored Residential (Family Training) Home
- ☐ DSS-Licensed Asst Living Facility-Not waiver provider
- ☐ Group Home (2-4 persons)
- ☐ Group Home (5-7 persons)
- ☐ Group Home (8 or more)
- ☐ Lives in apt/own home with others
- ☐ Children's Group Home

ICF/MR Level of Functioning ☐ Date completed

Check the following categories in which dependency level is met (must be met in 2 or more within 6 months of start date)

- ☐ 1. Health Status
- ☐ 2. Communication
- ☐ 3. Task Learning Skills
- ☐ 4. Personal/Self Care
- ☐ 5. Mobility
- ☐ 6. Behavior
- ☐ 7. Community Living Skills

Date Social Assessment Completed: _____

If SIS used, Support Needs Index: ☐

List the full range of services/supports that this individual receives/will receive:

Service Type	Services/Supports	Provider Name	Amt / Frequency	Start Date
Case Management				
Residential Support	In-Home			
			Periodic Supp=	
	Congregate			
If more than one provider, enter 2nd here →			Periodic Supp=	
Day Support [**MR or DS Waiver**]	Regular Intensity, Center-Based			
	Regular Intensity, Community-Based			
	High Intensity, Center-Based			
If more than one provider, enter 2nd here →	High Intensity, Community-Based			
Prevocational [**MR or DS Waiver**]	Regular Intensity, Center-Based			
	Regular Intensity, Community-Based			
	High Intensity, Center-Based			
If more than one provider, enter 2nd here →	High Intensity, Community-Based			
Supported Employment	Individual Placement			
	Group			
If more than one provider enter 2nd here →				

Individual's Name: _____ (LAST) _____ (FIRST) _____ (M.I.) Medicaid #: _____

Service Type	Services/Supports	Provider Name	Amt / Frequency	Start Date
Personal Assistance	Agency Directed			
		[redacted]	Periodic Supp=	[redacted]
	Consumer Directed			
		[redacted]	Periodic Supp=	[redacted]
Skilled Nursing If more than one provider enter 2nd here →	LPN			
	RN			
Respite	In-Home			
	Out-of-Home			
	Residential			
	Center-Based			
If more than one provider enter 2nd here →	Consumer Directed			
Companion	Agency Directed			
	Consumer Directed			
Therapeutic Consultation	Behavioral			
	Psychological			
	Physical			
	Speech			
	Occupational			
	Recreational			
	Rehabilitation Engineering			
Crisis Stabilization	Clinical / Behavioral Intervention			
	Crisis Supervision			
Environmental Modification				
Assistive Technology				
PERS (Personal Emergency Response System)	PERS			
	PERS and Medication Monitoring			
NON-WAIVER SERVICES				
School				
Medical				
Mental Health				
OT/PT/SP Therapy				
Other				

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

_____ _____
Case Manager Signature Date

_____ _____ _____
Individual/Guardian Signature Authorized Representative Signature Date